Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TARRANT COUNTY SURGICAL CENTER
914 LIPSCOMB STREET
FORT WORTH TX 76104

Respondent Name

NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-4567-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to the EOB received Dated 03-02-2011 stating that our claim Denied due to 'Auth was obtained for Texas Pain Institute and not for the Facility (Tarrant County Surgical Center) where the procedure actually took place, after all the investigation and review on this claim and on the findings it has come to my attention that 'Dr. Aggarwal was the referring physician and is also the Group physician for the Tarrant County Surgical Center' therefore, when we requested the Authorization for this procedure, the authorization form did say at the top of the page (which I have included in my documentation for process review) shows VED V. AGGARWAL, M.D., P.A., Corvel, did not emphasize any place of service for this procedure to take place, only the Dr.'s name which is listed on the procedure of this to take place. I have attached the Chart Notes showing that Dr. Aggarwal signed and was the physician that did the procedure."

Amount in Dispute: $1016.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

Response Submitted by: None

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 26, 2011	ASC Services for code 64483-SG	$1016.92	$0.00
	ASC Services for code 64484-SG		$0.00
TOTAL		$1016.92	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600, titled *Preauthorization, Concurrent Review, and Voluntary Certification of Health Care*, effective May 2, 2006 sets out the procedures for health care providers to obtain preauthorization for specific healthcare services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 2, 2011
   - 197-Payment adjusted for absence of precert/preauth.
   - SG-Ambulatory Surgical Center (ASC) Facility Service.

Issues

1. Did the requestor support position that preauthorization was obtained for the disputed services?
   Is the requestor entitled to reimbursement?

Findings

1. Based upon the submitted explanation of benefits, the disputed services were denied reimbursement based upon "197-Payment adjusted for absence of precert/preauth."

   On January 25, 2012, the Division obtained a copy of the preauthorization report dated December 28, 2011 from the respondent.

   The report reveals that the preauthorization was obtained for the following CPT codes: 62311, 72275, 77003 and 01992.

   28 Texas Administrative Code §134.600(f) states "The requestor or employee shall request and obtain preauthorization from the carrier prior to providing or receiving health care listed in subsection (p) of this section. Concurrent review shall be requested prior to the conclusion of the specific number of treatments or period of time preauthorized and approval must be obtained prior to extending the health care listed in subsection (q) of this section. The request for preauthorization or concurrent review shall be sent to the carrier by telephone, facsimile, or electronic transmission and, include the:
   (1) specific health care listed in subsection (p) or (q) of this section;
   (2) number of specific health care treatments and the specific period of time requested to complete the treatments;
   (3) information to substantiate the medical necessity of the health care requested;
   (4) accessible telephone and facsimile numbers and may designate an electronic transmission address for use by the carrier;
   (5) name of the provider performing the health care; and
   (6) facility name and estimated date of proposed health care."

   Based upon the submitted preauthorization report, the disputed services CPT code 64483-SG and 64484-SG were not listed; therefore, the requestor has not supported position that preauthorization was obtained per 28 Texas Administrative Code §134.600(f); reimbursement is not recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that the requestor failed to support its position that reimbursement is due. As a result, the amount ordered is $0.00.

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ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		2/23/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.